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The Department of Health & Mental Hygiene



# 5 Year Plan for AIDS
## 1989 - 1993



Executive Summary

AIDS Administration

## EXECUTIVE SUMMARY

The AIDS Administration was created as a separate administration within the Department of Health and Mental Hygiene in July, 1987, in recognition of the fact that the epidemic of AIDS, HIV infection, and AIDS-related fear had become a major public health concern for many Marylanders. In the past year, the AIDS Administration has simultaneously developed an administrative structure to deal effectively with organizational problems of acquiring space, equipment, staff, and budget; developed outreach and education networks in the community; addressed the health care needs generated by the epidemic; and addressed many facets of public health policy.

Most FY 1988 actions proposed in last year's Five Year Plan have been completed. Accomplishments include development of the AIDS Partnership Council to forge public-private communication and cooperation, development of the Center for AIDS Epidemiology to enhance the surveillance capabilities, development and staffing of outreach programs to the gay and bisexual communities and to minorities, expansion of public education and hotline services and development of education for health care professionals. In the area of AIDS treatment/patient services, the Administration was successful in obtaining both state and federal resources to expand the HIV Counselling and Testing Services (CTS) Program now operating in all 24 local jurisdictions. Two HIV diagnostic evaluation units were established. Treatment services for IV drug users continued to expand, and all addictions programs receiving Department of Health and Mental Hygiene funds began risk assessment and counselling for all clients.

No scientific discoveries have occurred in the past year which mandate a change in direction or priorities in fighting the epidemic. Primary prevention is still the best defense, and education leading individuals to adopt safe behavior patterns is the only mechanism available to prevent transmission. Public health officials can only break the chain of transmission if individuals assume personal responsibility for adopting safer lifestyles and avoiding high risk behaviors.

This year's plan continues to address the categories of statewide coordination, which has been broadened to include state agency coordination efforts; surveillance and epidemiology, which encompasses not only case-finding but also seroprevalence and knowledge, attitude and behavior studies to help us to understand those who are at risk and to evaluate the success of our interventions; prevention, which includes public education and outreach to groups at disproportionate risk for HIV infection; and health services, which includes HIV counselling and testing

services, treatment services for persons with HIV infection, and drug programs for drug addicts who are willing to enter treatment. Professional education for nurses, physicians, dentists, and other health care providers has been separated out of the section on prevention and given a section of its own. Professional education includes both educating health care workers to care for persons who have HIV disease and educating workers about "Universal Precautions," the current state of the art for preventing transmission of HIV through workplace exposures to blood or body fluids.

This Five Year Plan lays out plans which go well beyond specific resource commitments which have been made. Long range plans are intended to direct, not follow, resource commitments. Without allocation of federal or state funds in FY 1990 through FY 1993, modifications to the plans will have to be made. New developments - scientific discoveries, new drugs, vaccines, improved understanding of human behavior - may require change in direction. Nonetheless, the Five Year Plan FY 1989 - FY 1993 is the best blueprint for future actions that we can offer at this time.

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## I. INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS) is a new disease. In 1981, the Centers for Disease Control (CDC) reported five cases of a rare pneumonia in gay men who had severe immune deficiency without obvious cause. Since that time, the scientific community has made remarkable strides:

- o defining the epidemiology, pathogenesis and transmission (sexual, parenteral & perinatal);
- o identifying the Human Immunodeficiency Virus (HIV);
- o developing a very reliable test for detecting the antibody;
- o improving treatment for the serious opportunistic infections and malignancies;
- o developing a specific drug (Azidothymidine - AZT) which appears to prevent viral replication, forestalling further deterioration of the immune system and prolonging life.

Infection with HIV can manifest with a spectrum of pathology from asymptomatic infection to the final picture of AIDS and death. Once infected, an individual is capable of transmitting the virus for the rest of his life. Currently, only the complex of specific characteristics meeting the case definition of AIDS is reportable. Therefore, existing Maryland statistics on reported cases reflect only the end point of HIV infection. Seroprevalence data, which would indicate how many Marylanders are actually infected with HIV, is not available.

Projections of the number of Marylanders now infected with HIV, the number who will be infected over the next few years and the number who will develop AIDS over the next several years are generated from U. S. Public Health Service projections developed at the Coolfont conference in 1986 and revised at a follow-up conference this year in Charlottesville. (See Appendix A.)

The incubation period from infection to development of symptomatic disease is estimated to be from 5-10 years. It is currently estimated that 80% of those infected will develop the disease. However, as more is understood about the pathogenesis, it may be found that 100% of those infected will eventually develop disease.

The first Five Year Plan (FY 1988-FY 1992) for the Department's AIDS program was presented in October of 1987 -- less than two months after the appointment of a director for the newly-formed administration. Section II of this plan describes the progress made by the administration in achieving the FY 1988 action steps set forth in that plan. Naturally, with time for organization and reflection, with experience, and with the addition of new staff with new ideas, some of the specific action plans described in the original Five Year Plan have changed; additions and deletions have been made; and timing has been altered. In section III (p. 15) of this year's plan, notations have been made to indicate to the reader which areas are new or substantively changed from the prior plan. ("New" after an action indicates that it was not anticipated in the prior plan; "revised" indicates that the activity was addressed but that the specific plans have been changed; "unchanged" means that an item was included in the prior plan in the same way as in the current plan.)

One policy (and regulation) change has been anticipated and incorporated into the underlying assumptions of the current plan: that reporting of symptomatic HIV positive persons will be required in Maryland. Regulations which would require this reporting have already been drafted by the Department and reviewed by the Governor's Advisory Council on AIDS. Such reporting would have a substantial impact on our understanding of HIV infection and disease and on our ability to track the epidemic in Maryland.

Other changes from the original plan have been organizational. Both the sections on statewide coordination and surveillance have been broadened to reflect the full extent of activities. Within Section III C, Prevention, a separate section on Youth Outreach reflects the current organization of the administration. Similarly, Section III D, Professional Education, reflects the inclusion of professional education within the Assistant Directorate for Patient Services, rather than with public education and outreach.

In preparing this plan, the AIDS Administration has not assumed passage of any new legislation which would mandate screening of any particular group of people, increased reporting of persons with HIV infection, or other restrictive measures. A number of states have passed laws mandating HIV antibody screening of specific groups, such as marriage license applicants. Public health officials do not consider this to be a cost-effective tool; and, in fact, Illinois has already

repealed its marriage license applicant screening law. Mandatory screening simply encourages high risk persons to avoid those situations in which testing would be required--frequently resulting in avoiding contacts with public health officials who could offer anonymous, voluntary screening and counselling and other needed health services.

In Maryland, we feel that the issue of mandatory reporting of HIV positive individuals has been addressed adequately by the draft regulations on reporting of symptomatic HIV positive cases and the legislation passed in 1988 (HB 1329, Health General Article §18-207) requiring aggregate reporting of HIV antibody test results by all laboratories in Maryland. Where restrictive legislation is passed, public health officials lose the trust of the high risk individuals whose cooperation is needed in order to contain the epidemic of HIV infection. The Department of Health and Mental Hygiene strongly discourages restrictive legislation that will undermine such cooperative efforts.

It is difficult to develop a five-year plan for a disease such as AIDS. New discoveries may substantially alter means of preventing or treating HIV infection. Experience may demonstrate that some education/prevention efforts are ineffective and must be revised or discarded. It must be recognized that knowledge and practice are rapidly evolving. A vaccine or effective treatment could make our plans obsolete, and require swift changes in the direction of our efforts.

Nonetheless, planning is necessary. But these plans, and the dollars attached to them, must be viewed as tentative estimates of need

The larger demands of public health and state government will force priority setting and will limit resources that will be available to the Department of Health and Mental Hygiene for AIDS-related activities. Without funding, the Administration will not be able to implement all of the activities described in this Five Year Plan. This Plan, however, will be the blueprint to guide our future actions.

## II. FY 1988 PERFORMANCE

The AIDS Administration was created in July, 1987, to centralize Maryland's efforts in combatting the epidemic of HIV infection. The epidemic did not provide the luxury of time for the administration to organize itself. Instead, time-consuming organizational activities were performed simultaneously with expanding efforts in surveillance, prevention, and health services development to address the pressing demands generated by the HIV epidemic.

Both organizationally and programmatically, much has been accomplished. Staff has been expanded significantly; most contractual employees will be transferred to regular positions within a few months. Linkages have been forged in the gay/bisexual and minority communities and on college campuses, to facilitate outreach and education among populations which have been impacted upon most severely or are engaging in high risk behaviors. New or expanded health services are available to help mitigate the effects of AIDS and HIV infection.

Performance on the specific FY 1988 action steps outlined in the original Five Year Plan is described below. (A chart summrizing the status of FY 1988 action steps can be found in Appendix B.)

### A. Statewide Coordination

Objective: Plan and coordinate the AIDS efforts of public and private sectors.

FY 1988 Actions

1. Establish the AIDS Action Council.

   Status: The AIDS Partnership Council was initiated in January, 1988.

2. Develop a plan committee and planning process for this Council.

   Status: A steering committee was appointed at the first meeting and was charged with developing objectives and an operational agenda.

3. Develop a comprehensive statewide plan for AIDS prevention and treatment with clearly delineated public and private sector responsibilities.

Status: After careful consideration, the AIDS Partnership Council decided to defer the community-based needs assessment/action planning process until the group is functioning and is a recognized organization.

4. Develop a mechanism within the Council to maximize grants and funds available by submitting collaborative proposals.

Status: This has not yet been addressed by the AIDS Partnership Council.

B. Surveillance

Objectives:

1. Develop epidemiological techniques to facilitate planning for programs and resources.

2. Evaluate effectiveness of prevention and treatment strategies.

FY 1988 Actions

1. Enhance the staffing to enable the surveillance - data collection, analysis and compilation for use in planning - to be implemented.

Status: Additional staff epidemiologists have been added, as planned.

2. In collaboration with the Governor's Council on AIDS, develop the proposed legislation which will support the anonymous aggregate reporting of seropositivity.

Status: Legislation passed during the 1988 session of the General Assembly (HB 1329 and SB 826) and signed into law (Health General Article §18-207) requires laboratories in Maryland performing tests for HIV to report to the Department of Health and Mental Hygiene monthly the total number of tests performed, the total number of tests with confirmed positive results, and the total number of indeterminate test results.

3. Improve the distribution of data to the public and private sector.

Status: Case information has been included in an AIDS Update which is published monthly and distributed to interested persons statewide. The Surveillance Division responds to statistical requests from governmental agencies, academic institutions, and the media. The physician's newsletter, mailed to all physicians licensed and residing in Maryland, includes monthly AIDS statistics as well as other AIDS-related articles.

C. Prevention

Objective: Educate the population to effect behavior changes in order to reduce virus transmission and foster appropriate public responses.

FY 1988 Actions

1. Gay and Bisexual Outreach

a. Establish community networks within the city and on university campuses to enable the educational process.

Status: Networks have been established. Campus youth outreach has been an especially active component of the Gay and Bisexual Outreach Program and will become a separate program during FY 1989.

b. Use the three gay newspapers (one in Washington and two in Baltimore) to reach out with articles, a regular column and advertising for education.

Status: All three gay newspapers were used to reach the gay/bisexual population.

c. Plan a regional outreach center for Baltimore City.

Status: The FY 1989 budget includes

funding for a Gay/Bisexual Outreach Center in Baltimore City, which will provide services statewide. The procurement process to obtain rental space is underway.

2. Minority Outreach

a. Develop networks within the minority communities to guide planning and implement risk reduction strategies.

Status: The Outreach to Minorities Program has established networks within both the black and Hispanic communities. A major conference was held in June, 1988, in conjunction with Morgan State University, focusing on "AIDS Prevention and Strategies in the Black and Hispanic Communities." Networking will be an ongoing activity.

b. Use newspapers with strong minority leadership to disseminate pertinent information about decreasing risk behavior and thereby the spread of this virus.

Status: During FY 1988, staff of the Outreach to Minorities Program participated in approximately 50 media activities, including radio talk shows; TV programs; newspaper interviews, editorials, and advertisements; and public service announcements.

c. Plan regional outreach center in Baltimore City.

Status: Due to close collaboration with the Baltimore City Health Department and surrounding jurisdictions, a regional outreach center is no longer planned.

d. Channel the approximately $200,000 the Administration recently received from

CDC specifically earmarked for the minority community to assist them to take an active role in AIDS outreach and education.

Status: Funding was distributed through six community-based organizations, four local health departments, and two state colleges/universities. These programs provide services ranging from development of Spanish language pamphlets and PSA's to special targeted outreach to minority youth in Baltimore City to knowledge-attitude-behavior surveys of migrant Haitian farmworkers.

3. Intravenous Drug User Outreach, Education and Prevention

a. Expand the SOAP outreach and education program to Anne Arundel and Baltimore County.

Status: Outreach and HIV education programs for drug users have been funded in each county. These are not "street outreach" programs, however, based on the needs of each jurisdiction.

b. Conduct mandatory training for all addiction program staff geared specifically to AIDS risk assessment and risk reduction counselling. All ASA drug and alcohol programs will be required to provide this counselling to every client within the first thirty days following admission to the program.

Status: Thirty-three (33) one day workshops were held, with average attendance of 22 addictions counsellors and caregivers at each; total attendance at all workshops was 727. The program included a basic AIDS information presentation followed by small

group activities designed to enhance addiction counsellors' knowledge and skills needed for AIDS risk assessment and risk reduction counselling. These workshops were staffed with educators from both the Office of Education and Training for Addictions Services and the AIDS Administration. AIDS risk assessment and risk reduction counselling is now being provided to clients in all alcohol and drug programs funded by the Alcohol and Drug Abuse Administration.

4. Public Education

a. Develop a complete multifaceted educational program in the Administration with the assistance of the Health Education Center of DHMH. The center will also evaluate Maryland CARES and assist in updating and modifying the program to enhance its activities.

Status: The Center for AIDS Education has been organized within the AIDS Administration to bring together all outreach and education programs within the Administration except those aimed at health professionals. (Specifically, the programs united were gay/bisexual outreach; minority outreach; and general public education including hotline services.) The DHMH Health Education Center performed an evaluation of the "Maryland CARES" curriculum and modifications/update were made as needed.

b. Add three new trainers to Maryland CARES.

Status: Three new trainers were hired; however, one was lost, leaving a net gain of two trainers.

(This program has been re-named "public education" and is so referenced in this document.)

5. School-Aged Children

a. MSDE grant from CDC to develop and implement a school age pupil education program.

Status: Maryland State Department of Education hired an AIDS education specialist. Guidelines for implementing the AIDS Education Bylaw (see next paragraph) were published. A materials package was sent to all local education agencies. Inservice training was held at locations across the state.

b. All schools are to be required to implement a comprehensive school education program for three levels.

Status: The proposed MSDE AIDS Education Bylaw, mandating the AIDS education described above, was passed in March, 1988. School systems must comply by September, 1988.

c. Peer outreach program for youth not in school in conjunction with Youth Service Bureau of the Juvenile Services Agency.

Status: Training was provided by Maryland CARES to many Juvenile Services Agency staff to prepare them to incorporate AIDS risk assessment and counselling into their work with out-of-school youth.

d. Extend teen AIDS hotline from metropolitan Washington to Statewide.

Status: No funding identified; not completed. However, the services of the existing AIDS hotline were expanded and the toll-free number was published

to encourage use of the hotline throughout the state.

6. Health Care Workers

a. The professional staff of the Administration will be involved in the planning and implementation of education for health care professionals. The professional education component of Maryland CARES will be tailored to meet the needs of all types of health care workers.

Status: "Maryland CARES" no longer includes professional (health care worker) education. The Assistant Directorate for AIDS Health Services has assumed this responsibility. The two nurses in that division made more than 50 presentations in FY 1988.

b. The Administration will continue to collaborate with the disease control and epidemiology staff of the Department in developing and disseminating infection control procedures related to HIV and reviewing policies and procedures drafted by other organizations (e.g. hospitals).

Status: Accomplished. The groups have collaborated in policy development and professional education.

c. The Administration will foster the development of University of Maryland at Baltimore (UMAB) as a primary resource for HIV training. The chairman of the Governor's Advisory Council and Chancellor of UMAB, Dr. Edward Brandt, will assist the Administration.

Status: Accomplished. A consortium of parties (including the AIDS Administration), directed by UMAB, applied for and received a federal grant to establish a "Regional AIDS Education and Training Center" to develop

professional education resources. The AIDS Administration is a member of the Maryland Regional Planning Group for the Education and Training Center.

7. Hotline

A Request for Proposals to operate the Maryland AIDS Hotline has been prepared. It is anticipated that an appropriate community provider will receive the award by February 1988 to commence operation March 1, 1988. This contract will be awarded for a three year period.

Status: Accomplished. The Health Education Resource Organization (HERO) was the successful bidder.

8. Mental Hygiene

a. The Mental Hygiene Administration will initiate an educational program for community providers - four regional workshops annually.

Status: Accomplished. Six workshops were held.

b. Consultants will be available to mental health providers for case consultation, treatment, supervision and continuing education.

Status: Not accomplished. Funding was not available.

D. Treatment/Patient Services

Objective: Ensure availability of comprehensive treatment for the whole spectrum of HIV disease from asymptomatic infection through the final stages, while maintaining the dignity and confidentiality of each patient.

FY 1988 Actions

1. Screening - reduce delays for obtaining screening by supplementing funding for local health departments from a CDC grant.

Status: Accomplished.

2. Open a new Counselling and Testing Site (CTS) in Frederick County.

   Status: Accomplished.

3. Subacute bed need is estimated to be between 9-18.

   Status: Seton Hill Manor Nursing Home opened a new 22 bed unit for HIV/AIDS patients.

4. Diagnostic and evaluation units (DEU).

   Status: Two units were established: an adult unit at the Johns Hopkins University and a pediatric unit at the University of Maryland.

5. Case Managers in local health departments.

   Status: Several health departments in metropolitan counties have case managers funded with State and/or local funds (Prince George's, Montgomery). The AIDS Administration initiated grants for two regional case managers, one for Western Maryland and one for the Eastern Shore.

6. The Addictions Services Administration will establish 75 slots for methadone maintenance and detoxification for referrals from the SOAP program. Fifty additional addicts will be allowed to enter treatment per month by the rapid medical intake system. Home Health Care for 20 IV Drug users with AIDS.

   Status:

   a. Seventy-five treatment slots were established for methadone maintenance and detoxification at the Behavioral Pharmacology Research Unit of Francis Scott Key Medical Center in Baltimore City. This program now serves 180 patients annually.

   b. The Rapid Medical Intake (RMI) system was expanded to accommodate

additional numbers of IV drug users seeking treatment due to the threat of HIV infection and AIDS, resulting in 1,000 intakes annually.

c. A home health care pilot was established at the Sinai Hospital Methadone Program. The program offers necessary drug related counselling and social services to drug clients who are homebound as a result of AIDS, and also offers education and supportive counselling to clients who are seropositive or have AIDS.

7. Maryland AIDS Drug Assistance Program (MADAP) - Azidothymidine (AZT)

Status: MADAP was initiated in October, 1987. Forty- nine (49) patients were enrolled during FY 1988. Federal support ends on September 30, 1988 at the close of the grant period.

## III. UPDATE: FY 1989 - FY 1993

This section updates the original plan and adds action steps for FY 1993. A table summarizing the action steps for FY 1989 through FY 1993 is included as Appendix C to this document.

### A. Statewide Coordination

In order to meet the challenge of AIDS in Maryland, DHMH must play a major role in planning, coalition building, and the establishment of partnerships throughout the public and private sectors. No level of government can possibly act alone to solve a problem of this magnitude; and, in fact, should not, when the solutions necessitate changes in the most private, personal behaviors and in the personnel policies of private industry, and innovations throughout the health care financing and delivery systems.

To stimulate and coordinate the involvement of diverse sectors of the community in AIDS prevention, treatment, and education, DHMH has initiated the AIDS Partnership Council. This Council has three purposes: 1) to help DHMH develop a comprehensive plan to combat AIDS in Maryland with a negotiated division of labor between public and private sector groups; 2) to assist DHMH in catalyzing and stimulating private organizations to pursue AIDS work, and to maximize the financial resources available for this work in Maryland; 3) to coordinate the efforts of interested organizations, minimizing both duplication and unmet needs.

Within state government, two important mechanisms are in place to help ensure a coordinated response to the HIV epidemic. One, the Governor's Interdepartmental AIDS Workgroup, was initiated in 1987 to facilitate information sharing and policy development among all executive agencies. Each agency was instructed to appoint a high-level representative to serve on this workgroup, which meets every month. During FY 1988, this group began producing the bi-monthly Governor's AIDS Fact Sheet, provided to state agencies for reprint or use in agency newsletters.

The second mechanism to effect a coordinated state-agency approach to the HIV epidemic is a review process for AIDS/HIV related materials, policies, educational curricula, etc. In February, 1988, Governor Schaefer instructed all

state agencies to send any AIDS-related materials or policies to the DHMH AIDS Administration for review and approval before release.

Objectives:

1. Plan and coordinate the AIDS efforts of the public and private sectors.

2. Ensure that all state agencies deal with AIDS/HIV issues in a consistent manner, in line with good public health policy.

FY 1989 Actions (All new)

1. The Aids Partnership Council will appoint a permanent steering committee and facilitate networking among members.

2. The Governor's AIDS Fact Sheet will serve as a source for HIV information in all state agencies.

3. The AIDS Administration will assist agencies in revising/developing HIV-related policies and educational materials.

FY 1990 Actions (New)

1. The AIDS Partnership Council will reconsider community-based needs assessment/action planning as a tool to meeting community needs.

B. Epidemiology (This topic was discussed under "Surveillance" in the original plan.)

Monitoring the impact of HIV on the population requires collection and analysis of epidemiologic data. The Center for AIDS Epidemiology within the AIDS Administration focuses on both surveillance of the HIV epidemic (identification and reporting of cases and seroprevalence studies which estimate the proportion of the population studied which is infected with HIV) and special studies (such as knowledge - attitude - behavior analyses of selected populations).

The challenge in planning preventive interventions is two-fold: to interrupt transmission patterns in populations currently bearing the burden of AIDS and to predict accurately and prevent its spread into new segments of the population. The success

of any intervention depends on application of accurate baseline data to the design of the intervention strategy.

The long-range outcome objective of HIV/AIDS prevention programs is to decrease morbidity and mortality associated with HIV infection. Impact objectives are the core of a prevention program. They trigger specific action and resource commitments within the program, and are defined by using data generated in epidemiologic surveys of knowledge, attitudes, and behaviors in specific population groups.

Once the impact of prevention strategies has been assessed, new strategies are based on the impact (success, partial success, failure) of previous ones.

1. Surveillance

Surveillance is, therefore, essential to planning. Between 1981 and 30 June 1988, 1201 persons met the CDC case definition for AIDS in Maryland. Of these, 60 percent (717) are dead. (See Appendices D and E.) A demographic examination of cumulative cases indicates that males, age group 30 - 39, blacks, residents of metropolitan areas, and persons of gay/bisexual orientation are disproportionately represented. (See Appendix F.) The demographic comparison of 1988 incident cases with cases diagnosed prior to this calendar year suggests that changes in these demographic patterns are occurring. Gays/bisexuals account for 53 percent of cases in 1988, while previously 63 percent of cases belonged to this group. Prior to 1988, blacks comprised 51 percent of cases; in 1988, the percentage rose to 59 percent. Cases in women in 1988 made up 14 percent of the total; this was an increase from 10 percent of cases diagnosed before 1988. The long incubation period between infection and development of CDC-defined AIDS, together with data comparison of 1988 to previous years, suggests that by the time AIDS was defined and surveillance was established, the transmission patterns of HIV were already changing, spreading HIV into new segments of the community.

a. Case Detection

Case detection relies on a network of hospital-based infection control officers whose regular duty is to monitor infectious disease occurrence within their individual hospitals. When an AIDS case is diagnosed, it is reported by the infection control officer to the AIDS Administration, and subsequently investigated by the Surveillance Division. The Baltimore City Health Department independently collects and investigates cases occurring within its limits and transmits information to the State. State death certificates are also monitored to detect any cases which have not been reported.

The CDC definition for AIDS was expanded to include presumptive diagnoses in August, 1987. The less stringent criteria for case definition may result in cases diagnosed in the community rather than in a hospital setting. In addition, new regulations have been drafted which would require the reporting of symptomatic HIV-infected individuals. The bulk of this reporting would probably be done by community physicians treating these individuals, since most would not require hospitalization at so early stage in their disease. The design and adequacy of the current reporting network must be assessed in light of these changes.

Reporting of aggregate results from all HIV antibody testing performed in laboratories in Maryland and reporting of positive results (without personal identifiers) in conjunction with the donation of blood, semen, or other tissue for use in the human body is required by two new laws which became effective July 1, 1988.

b. Seroprevalence

It is difficult to estimate accurately the seroprevalence in the general population since no randomized sampling results are available. A cumulative total of 60,947 specimens have been analyzed for the presence of antibodies

to HIV by the Maryland State (DHMH) Laboratories Administration through May, 1988. Specimens testing positive on the first test (ELISA) are confirmed positive by the Western Blot test. Seroprevalence varied by source of the specimen, ranging from 2.2% for proposed tissue/organ donors to 16.9% for specimens submitted from hospitals, with a mean cumulative seropositivity of 7.6%.

None of these rates is an accurate indication of population seropositivity. Some institutions (hospitals, for example) use the state laboratory only to confirm results on locally screened ELISA positive specimens, thus distorting the seropositivity rates. Most testing is done among individuals believing themselves to be at high risk for infection (e.g., gay males, attendees at STD clinics) and could be expected to produce seropositivity rates higher than that of the general population.

The seroprevalence rate for Maryland's military recruits (from tests conducted by the Department of Defense) is 0.33 percent (cumulative), which is 2.4 times higher than the national rate. Maryland's military recruit seroprevalence rates have been consistently higher than national rates for every quarter since October, 1985, when screening began.

Objectives: (Revised from prior plan)

1. Collect case data in order to:

   Define numerically the extent of the disease;

   Describe the demographic and transmission patterns of the disease;

   Document the clinical presentation;

   And evaluate the effectiveness of therapeutic intervention(s).

2. Collect seroprevalence data in order to:

Define the natural history of the disease;

Evaluate time from seropositivity to symptomatic state and survival time thereafter; and

Monitor and assess the impact of prevention strategies.

FY 1989 Actions

1. Expand the capability of the surveillance section with one new case investigator. (Unchanged)

FY 1990 Actions

1. Increase surveillance staff in response to (anticipated) new reporting requirement for HIV-infected symptomatic patients. An epidemiologist, secretary, and increased computer capacity would be needed. (New)

2. Repeat biennial blind seroprevalence studies of specific subpopulations (e.g., clients in STD, family planning, or drug abuse clinics; gays and bisexuals). (Unchanged)

3. Begin surveillance specific to the monitoring of pediatric AIDS cases. (New)

FY 1991 Actions

1. Add case investigator, if needed. (Revised)

2. Analyze data from reporting of symptomatic HIV seropositive individuals to add to understanding of the natural history of HIV infection. (New)

3. Conduct seroprevalence surveys in high-risk groups defined by CDC in its family of surveys. (New)

FY 1992 Actions

1. Repeat biennial blind seroprevalence studies of specific subpopulations. (Unchanged)

FY 1993 Actions (New)

1. Increase staff as necessary.

2. Special Studies

   A key to both design and evaluation of HIV prevention strategies is understanding relevant knowledge, attitude, and behaviors (KAB) of the target population. Surveillance, including seroprevalence studies, identifies specific groups experiencing disproportionate infection or disease. Epidemiologic surveys of knowledge, attitudes, and behavior help pinpoint specific factors (e.g., lack of knowledge, high risk behavior, feelings of invulnerability) which may relate to the severity of the HIV epidemic on a given group of individuals. Then interventions can be designed which focus on changing these specific factors. Groups targeted for KAB surveys include groups engaging in high risk behaviors; ethnic minorities; women of reproductive age; and the general population.

Objectives: (New)

Examine the HIV-related knowledge, attitudes, and behaviors of the general population and its various subsets.

FY 1989 Actions

1. Pursue contractual arrangement with the University of Maryland for data management. (Unchanged)

2. Perform KAB surveys: random sample of the general population; clients in family planning clinics; ethnic minorities; college-aged youth. (Revised)

3. Develop a pilot project to examine patterns of communication and information transfer within the family unit. (Eventually we hope to develop a model which would permit us to assist families to teach their own children safe behaviors in the context of their

individual religious and cultural heritage.) (New)

FY 1990 Actions

1. Conduct KAB surveys in conjunction with the seroprevalence studies in high-risk groups. (New)

2. Assess educational intervention in specific targeted populations. (New)

3. Undertake the second phase of the family communication and information transfer study. (New)

FY 1991 Actions

1. Repeat KAB surveys among a random sample of general population; clients in family planning clinics; ethnic minorities; and college-aged youth. (New)

2. Continue communication and information transfer study in families. (New)

3. Add a computer programmer with support to staff. (New)

FY 1992 Action

1. Conduct KAB surveys in conjunction with the seroprevalence studies in high-risk groups. (New)

2. Assess educational intervention in specific targeted populations. (New)

FY 1993 Actions

1. Repeat KAB surveys among a random sample of general population; clients in family planning clinics; ethnic minorities; and college-aged youth. (New)

C. Prevention

At this time, primary prevention is still the principal means for limiting the HIV epidemic. And the only tool for primary prevention - prevention of the spread of infection - is education of the public regarding HIV infection, transmission, and behavior modification to reduce the risk of acquiring the infection. Education must be

tailored to individual groups in order to incorporate social and cultural mores of the group. Varied strategies for education have been developed to address the needs of diverse groups, such as the general public, professionals, minority groups and populations whose behavior puts them at high risk for acquiring and disseminating the infection (e.g. intravenous drug users, gay/bisexuals, prostitutes).

"Maryland CARES" (Center for AIDS-Related Educational Services), previously used to denote the public education division, now encompasses all education efforts of the AIDS Administration, except those targeted to health care professionals. (Education of health care workers is discussed on pages 31 through 34 of this plan.)

The Center for AIDS Education (Maryland CARES) includes the Divisions of Public Education, Gay and Bisexual Outreach, Minority Outreach, and Youth Outreach. Cooperative ventures with established community organizations within targeted groups enhance the capability of the AIDS Administration staff to reach members of those groups.

Outreach to intravenous drug users (IVDU) is the primary responsibility of the Alcohol and Drug Abuse Administration. The SOAP (Street Outreach for AIDS Prevention) Program began in 1986 as a pilot project in the Baltimore area. Carefully selected and trained recovering IVDU's are hired as outreach workers. Workers meet with intravenous drug users and their partners in the community, provide educational and prevention information and assist in their referral into treatment programs.

The goal of AIDS education is not merely the acquisition of knowledge but rather, behavioral change. Experience shows that knowledge does not always lead to behavior change. Evaluation of program effectiveness must assess changes in knowledge, attitudes and behaviors.

Objective:

Educate the population to effect behavior changes in order to reduce virus transmission and foster appropriate public response. (Unchanged)

FY 1989 Actions

1. Gay and Bisexual Outreach

   a. Establish and staff an outreach center in a neighborhood with a large gay/bisexual population in Baltimore City. (Revised)

   b. Define four regions covering Maryland and deploy staff to serve all regions. (New)

   c. Target special programs toward ethnic minority males, sexual minority youth, and Maryland's deaf population. (New)

2. Outreach to Minorities (All New)

   a. Develop a communication network for minority organizations, state agencies and academic institutions.

   b. Develop a program for training community health aides to function as health advisors and AIDS educators in the minority community.

   c. Identify, fund and provide technical assistance to community based organizations conducting prevention/education services to minorities in specific regions of the state. Develop and implement a systematic approach to quality assurance for funded programs.

   d. Coordinate the design and implementation of culturally sensitive KAB studies of African-Americans, Hispanics and Haitian farmworkers in the State.

   e. Collect and/or develop culturally-sensitive training materials to be used in prevention/education projects.

   f. Establish a Minority Outreach Advisory Panel.

   g. Establish a minority outreach center on the Eastern Shore.

h. Establish an AIDS hotline for Hispanics in the metropolitan Washington, D.C. area.

3. Intravenous Drug Users

a. Conduct one-day training workshops and a one-week residential course for all ADAA drug/alcohol program counsellors and clinical staff to provide updated AIDS education and training in such areas as risk reduction, counselling, death and dying, AIDS and the family, etc. (New)

4. Public Education

a. Expand staff by two trainers and a resource librarian. (Revised)

b. Design and field test a skill-building workshop to augment the basic training curriculum/workshop now in use. (New)

c. Develop additional education materials, including a brochure for distribution to applicants at marriage license sites and a brochure encouraging community involvement in AIDS efforts. (New)

d. Develop and implement a plan to provide AIDS educators and educational materials to the LHD's on a regional basis to enhance their AIDS prevention efforts. (New)

e. Conduct a community education program via billboards to coincide with National AIDS Awareness Month. (New)

f. Provide consultation and materials to state libraries throughout the state. (New)

g. Expand hotline services to include TDD (telephone device for the deaf) capabilities. (New)

5. Youth Outreach (All New Action Steps)

a. Establish a separate Division of Youth Outreach within Maryland CARES.

b. Conduct a beach outreach program for young vacationers at Ocean City; evaluate.

c. Focus on staff training in assisting with implementation of the Education Bylaw mandating AIDS education in the schools.

d. Conduct focus groups with out-of-school youth to assess needs and communications strategies.

e. Provide staff inservice training and help to develop a curriculum for training clients within the Juvenile Services Agency or other organizations serving high-risk youth.

f. Collaborate with the Interagency Committee on Teenage Pregnancy and Parenting and with community-based organizations serving youth.

6. Mental Health

a. Employ a half-time staff person in the Mental Hygiene Administration to address AIDS-related issues. (New)

b. Conduct at least six regional educational programs for mental health care providers. (New)

FY 1990 Actions

1. Gay and Bisexual Outreach

a. Prepare for a two-year STOP AIDS Project in the Baltimore/Washington Corridor. (STOP AIDS is a project which uses community-based organizations to develop local discussion groups where information, together with peer pressure, are used to encourage safe sex behavior.) (New)

b. Expand programs serving special populations (minority males, sexual minority youth and deaf persons). (New)

2. Outreach to Minorities

a. Initiate a quarterly update bulletin for the minority communications network. (New)

b. Expand the program of training community health aides. (New)

c. Establish a consortium of black colleges to provide training, consultation and collaboration with minority organizations providing outreach/education services. (New)

d. Expand funding for community-based organizations.

3. Intravenous Drug Users

a. Add regional AIDS outreach/prevention coordinators in Central Maryland, Western Maryland, Southern Maryland and the Eastern Shore. (Unchanged)

b. Add six new positions to the SOAP program in Baltimore City; put special emphasis on reaching minority IV drug users, prostitutes, sexual partners of IV drug users, and children of drug users. Fund a mobile van for the SOAP program in Baltimore City. (Revised)

c. Expand the SOAP program in Prince George's County from two part-time to five outreach workers; and expand the outreach and HIV education program for drug users in Anne Arundel County from 1 part-time to 1 full-time position. (Revised)

4. Public Education

a. Provide consultation and training to the private sector. (New)

b. Implement skill-building workshops as part of the training program. (New)

5. Youth Outreach (All New Actions)

a. Implement a mechanism for colleges/universities to share AIDS prevention information and training materials.

b. Develop training materials for specific groups or settings, such as youth outreach in resort areas.

c. Focus on educational opportunities for parents and parent groups with respect to the Education Bylaw; conduct an assessment of needs for training materials aimed at assisting families to educate their children regarding HIV-related health issues.

d. Fund demonstration projects in pregnancy and HIV prevention.

FY 1991 Actions

1. Gay and Bisexual Outreach (New Action Steps)

   a. Implement STOP AIDS Project in the Baltimore/Washington corridor.

   b. Plan for expanding the STOP AIDS Project to other areas of the state.

2. Outreach to Minorities (New Actions)

   a. Conduct workshops/conferences in each state region to promote sharing within the established communications network.

   b. Conduct comprehensive evaluation of the community health aide training program and other manpower efforts relative to AIDS prevention in minority communities.

   c. Expand funding for community-based organizations and local health departments.

3. Public Education (New Action Steps)

   a. Re-bid contract for hotline services.

   b. Expand regional AIDS education program from 6 to 7 regions.

4. Youth Outreach (New Actions)

   a. Focus on updating the training of staff involved in AIDS education in the schools.

b. Acquire staff person to assist agencies serving children with specialized needs to include HIV/AIDS education in Individual Educational Plans developed for each student.

FY 1992 Actions (New Actions)

1. Gay and Bisexual Outreach

   a. Evaluate the STOP AIDS Project in the Baltimore/Washington corridor.

   b. Review data to identify specific geographic areas where there may be concentrations of HIV infection among the target population.

   c. Establish regional outreach center in the Washington, D.C. metropolitan area.

2. Outreach to Minorities

   a. Expand, if appropriate, manpower programs based on evaluation done in FY 1991.

   b. Increase regional outreach staff from 4 to 6 workers.

   c. Seek additional funds for community-based organizations or local health department programs of minority education.

3. Public Education

   a. Expand regional AIDS educator program from 7 to 8 regions.

4. Youth Outreach

   a. Establish a campus site as the statewide center for campus-based training materials; make training materials available through an electronic communication system.

   b. Increase staff in order to provide attitudinal and skill-building workshops for educational staff and parent groups.

   c. Determine feasibility of including AIDS prevention materials within GED

("General Equivalency Diploma") and literacy programs.

FY 1993 Actions (New Actions)

1. Gay and Bisexual Outreach

   a. Analyze epidemiologic data to determine if primary prevention efforts have been successful. Such evaluation is only feasible after several years due to the long incubation period between infection and manifestation of symptoms.

   b. Establish outreach centers in Western Maryland and Eastern Shore.

   c. Develop regional outreach programs with neighboring states to reach gay and bisexual men that travel between states for recreational purposes.

2. Outreach to Minorities

   a. Contract with an outside agency to conduct a review of all minority outreach programs and services.

   b. Increase regional outreach workers from 6 to 8.

   c. Establish an ongoing training program for minority community-based organization staff. Training will be given in areas designed to improve the capability of staff to reach minority populations.

3. Public Education

   a. Contract with an outside agency to conduct a review of all Public Education Division programs, materials and services.

   b. Expand regional AIDS educator programs from 8 to 10 regions.

   c. Implement extensive media advertising (TV, radio, billboard) campaign.

4. Youth Outreach

a. Establish a youth outreach center in the Washington, D.C. metropolitan area.

b. Establish an interagency committee of state agencies. This committee will develop programs for out-of-school youth.

D. Professional Education

Education of health care professionals regarding HIV infection/AIDS is a critical part of the mission of the AIDS Administration. The Administration regards the educational needs of health care workers as distinct from those of the lay public. The Assistant Directorate for AIDS Health Services focuses on the educational needs of all levels of health care professionals. The Administration works with local health departments, the health professional schools and private practitioners by providing direct AIDS education through workshops or seminars and by assisting in development of educational programs. In addition, as the Diagnostic Evaluation Units develop, they will serve an important role in providing opportunities for hands-on training of health professionals.

There are three purposes for HIV-related education for health care workers. First, specialized education is needed to ensure that there are sufficient health care professionals with appropriate training to serve the needs of patients with HIV disease. Second, health care professionals should be trained to provide HIV risk assessment and counselling to their patients. Third, all health care workers, as well as others who might come into contact with human blood or body fluids, need information about infection control procedures adequate to prevent transmission of HIV.

Infection control procedures have assumed increased importance with the advent of AIDS and HIV. Since it has been estimated that for every reported case of AIDS, there may be thirty people infected with HIV (many of whom do not know they are infected), health care workers or others exposed to blood or body fluids cannot hope to identify all those who are infected with HIV. Therefore, updated CDC guidelines require application of appropriate infection control procedures to all persons, not just those known to be infected (the principle of "Universal

Precautions"). Developing policies to implement Universal Precautions, in collaboration with agencies such as Maryland Occupational Safety and Health (MOSH) and the Department of Personnel, is an important first step in educating health care workers.

Objectives: (All new)

1. Educate health care workers to respond to the demands of the HIV epidemic, including prevention, counselling and testing, diagnosis and treatment.

2. Educate all levels of health care workers and other at-risk employees regarding modes of HIV transmission, decrease fears of transmission and provide information and skills needed to apply the CDC "Universal Precautions" for infection control.

FY 1989 Actions (All new)

1. Expand professional staff by adding two nursing positions, one focused on general health care worker education and the other dealing more specifically with infection control issues.

2. Contract with the University of Maryland at Baltimore (UMAB) to provide a University-based nurse liaison/coordinator between the six professional schools and the professional education staff of the AIDS Administration.

3. Plan and begin survey of HIV-related knowledge, attitudes, and behaviors of Maryland-based physicians.

4. Contract with UMAB, School of Dentistry to conduct a KAB study of Maryland dentists' infection control practices.

5. Fund a dental health professional to assist the State Dental Director to initiate HIV-related education for dental professionals.

6. Publish the Communicable Disease Bulletin, a monthly publication sent to 12,000 Maryland physicians, featuring information on epidemiology, diagnosis and treatment, HIV prevention, HIV counselling and testing, and available public health services.

7. Foster the role of the Diagnostic Evaluation Units as consultation resources and clinical training sites.

8. Develop and disseminate infection control procedures related to HIV and assist with developing and reviewing policies and procedures of other organizations, including the Maryland Occupational Safety and Health (MOSH) Agency.

FY 1990 Actions (All new)

1. Expand contract with UMAB to include liaison plus services of representatives from the six professional schools for curriculum development.

2. Complete survey of physicians and plan KAB survey of nurses. (Results will be used in conjunction with curriculum development at UMAB, previous action step.)

3. Establish a statewide coordinating council on HIV infection control to share latest knowledge on new techniques, to review and update infection control procedures in light of CDC recommendations, and to develop patient care recommendations.

4. Plan and pilot a Health Care Worker Exposure Consultation Service through four local health department CTS clinics.

5. Request federal support for two additional infection control practitioners plus clerical support to assist in implementing the MOSH standard in Maryland.

FY 1991 Actions (All new)

1. Implement HIV education within the six professional schools at UMAB.

2. Complete survey of nurses; consider similar survey of allied health professionals.

3. Add six counties to demonstration project to establish a Health Care Worker Exposure Consultation Service through the local health department CTS clinics.

4. Review licensing and credentialing processes of all categories of health care workers and

promote inclusion of a minimum requirement for annual continuing education credits in HIV-related education. In-kind

FY 1992 Actions (All new)

1. Update curricula for professional education at UMAB as needed and continue to incorporate into the ongoing program.

2. Conduct survey of knowledge, attitudes, and behaviors of allied health professionals.

3. Expand Health Care Worker Exposure Consultation Service to all jurisdictions.

FY 1993 Actions (All new)

1. Evaluate programs implemented at UMAB.

2. Develop programs to meet education needs identified in the survey of allied health professionals.

3. Evaluate data collected through Health Care Worker Exposure Consultation Service.

E. Health Services

The continuum of HIV related health services (see Appendix G for a schematic representation of the continuum of services in Maryland) includes HIV testing and counselling; voluntary partner notification for seropositives; medical follow-up of seropositives; acute, subacute, or residential care for persons with symptomatic HIV infection or AIDS; and mental health services for those who are infected and their family/support networks as well as for the "worried well." In view of the role of intravenous drug user in the transmission of HIV, treatment programs for IV drug users must certainly be considered a part of HIV related health services.

The Department of Health and Mental Hygiene does not generally deliver health services from the State level. Its role in the health care system ranges from planning and encouraging development of needed services, through policy formulation and regulation, to financing needed services. The twenty-four local health departments function as the Department's service arm, offering direct services in response to assessed need in the community. All local health departments have

established basic HIV counselling and testing services in their jurisdictions. In some areas with a significant number of HIV seropositives who do not have a private source of medical care (or funds to access private medical care), local health departments are meeting the need by establishing seropositive follow-up clinics. When more specialized consultation or acute medical care is required, services may be provided by private sector resources (medical specialists, hospitals, chronic care facilities). The Department's role then becomes one of encouraging development of needed services and providing financial support (through direct contract and/or financing through the Medical Assistance Program) for needed services.

1. HIV Testing

As indicated above, all jurisdictions have established free HIV counselling and testing services (CTS). Originally envisioned as providing alternate test sites to discourage high-risk individuals from donating blood in order to be tested, the CTS Program now provides intensive risk reduction counselling to all those who seek testing (pre-test counselling), HIV antibody testing for those who decide to have the test (98%), and follow-up (post-test) counselling for those who return for test results. Post-test counselling for seropositives is particularly intensive, and includes supportive counselling, referral to medical care for follow-up, and a discussion of the seropositive individual's responsibilities for preventing further transmission, including voluntary partner notification, with or without the help of a clinic counsellor. (See Appendix H for data on Maryland's CTS clinics.)

HIV testing is accessed not only through the CTS Program, but also through private medical care providers. The State Health Department Laboratory provides free analysis of specimens to both public and private providers. Other laboratories also do HIV testing, often performing the lower cost ELISA tests in-house on all specimens but sending specimens testing positive on the ELISA on to the State laboratory for the more expensive, confirmatory, Western Blot test.

There is, at present, no way to monitor or control what, if any, risk reduction counselling or messages are provided when HIV testing is performed outside of the CTS . An information package providing basic risk reduction messages, including a discussion of the importance of partner notification for seropositives, was developed to help address this gap in services. The packet is sent back to a medical care provider with each positive test result. Ideally, the provider reviews its contents with his/her patient when he/she discusses the test result; at a minimum, the provider should pass the packet on to his/her patient.

CDC recommends and Maryland law now requires screening for blood, tissue, organ and sperm donors. Other screening is voluntary but recommended for high risk populations. Enormous increases in cost and workload could be anticipated if mandatory screening were legislated. Similar increases would result if an effective treatment strategy for HIV infection became available, making screening an efficient means to channel individuals into treatment.

2. Patient Care

HIV infection and its related diseases present a serious challenge to the health care system. In Maryland, inpatient acute care services are available to all patients, including those unable to pay; but the cost of this care is still a burden to society. AIDS patients requiring subacute care are competing for beds with the aged and deinstitutionalized. The constraints of licensure for chronic care institutions have severely limited the growth of subacute care beds in Maryland. When subacute care beds are not available, the result can be unnecessary, costly, prolonged stays in acute care hospitals or premature discharge of patients to the home.

Using the Project Home model from mental health, the Department of Human Resources has developed a network of 25 adult foster care homes which can be used for supervised residential placements of persons with HIV infection or AIDS who have no homes or cannot return alone to their homes. As of July 1,

1988, fifty-four (54) persons with HIV /AIDS had used this service.

3. Mental Health Services

The needs of the "worried well" (persons not infected but who fear that they might be), persons identified as seropositive, symptomatic patients and their families have rapidly increased the demand for ambulatory mental health services.

Private sector response to the need has been good in certain communities (e.g., the gay/bisexual programs of Health Education Resources Organization and the Chase-Brexton Clinic of the Gay and Lesbian Community Center). There are significant unmet needs. At any time the three state mental health hospitals in the metropolitan area have 2 to 5 known HIV infected patients.

4. Addictions Services

Intravenous drug use (IVDU) treatment is essential if HIV transmission is to be curtailed. Methadone treatment programs, in particular, provide a positive alternative for IV drug users who are motivated enough to enter treatment; and they provide a structured setting for client HIV risk assessment and counselling. Development of additional treatment slots so that addicts referred from the SOAP Program (see p. 21) will have immediate access to treatment is a priority. The Alcohol and Drug Abuse Administration has also developed a pilot home care program for addicts on methadone who are homebound due to HIV infection/AIDS.

Objective:

Ensure availability of comprehensive services for the whole spectrum of HIV disease from asymptomatic infection through the final stages, while maintaining the dignity and confidentiality of each patient. (Unchanged)

FY 1989 Actions

1. Counselling and Testing Services

   a. Expand HIV counselling and testing into local health department

sexually transmitted diseases, family planning, and maternal health clinics. (New)

b. Increase local health department counselling/testing, partner notification, and seropositive follow-up capabilities through allocation of Case Formula funding. (New)

c. Add a nurse for training of staff in CTS clinics. (New)

2. Patient Care

a. Establish seropositive follow-up clinics in Baltimore City and Prince George's County. (Revised)

b. Establish a regional Diagnostic Evaluation Unit (DEU) Service for Prince George's and Montgomery Counties. (Moved forward from FY 1990)

c. Develop and implement ongoing DEU evaluation methodology, intake form, and analysis of demand. (New)

d. Assess the needs of pediatric HIV-infected patients through hospital discharge data, clinic visit data, DEU utilization, and case management services demand analysis. (New)

e. Expand number of local health services coordinators: Baltimore City - 2; Baltimore County - 1/2. (New)

f. Augment AIDS Health Services staff to include a statewide local health department services nurse coordinator. (New)

g. Contract with a third party to extend the Maryland AIDS Drug Assistance Program (MADAP) until all federal funds have been spent. Existing funding only. (New)

3. Mental Health Services

a. Conduct a needs assessment survey to determine whether there is an unmet need for mental health services among HIV positive people and to identify barriers to service utilization by this group. (New)

4. Addictions Services

a. Establish a 60 slot methadone to abstinence program for narcotic addicts in Montgomery County. (Revised)

b. Establish AIDS education and support groups for drug treatment patients who have tested seropositive and/or are of childbearing age. Counsellors at 7 Baltimore City and 1 Prince George's County methadone programs will conduct these groups as well as provide in-service education to the program staff and community. (New)

FY 1990 Actions

1. Counselling and Testing Services

a. Seek additional federal funding for local health department CTS services. (New)

b. Collaborate with Local Health Administration to assure appropriate and continued implementation by local health departments of CTS - related programs initiated through designated Case Formula support in FY 1989. (New)

c. Request federal support for two professional social workers to assist local health department CTS counsellors meet the demands of their jobs and manage job-related stress. (New)

2. Patient Care

a. Expand local health department seropositive follow-up services. (New)

b. Increase the number of health service coordinators, concentrating on areas with higher seroprevalence rates and high caseloads. (Revised)

c. Recruit and hire special projects coordinator to monitor, evaluate, and facilitate progress of DEU contracts. (New)

d. Obtain funding (federal or state) to continue the Maryland AIDS Drug Assistance Program (MADAP) 54 slots plus one full-time equivalent administrator. (Unchanged)

3. Mental Health Services

a. Expand services based on FY 1989 demand and results of needs assessment survey. (New)

b. Initiate one specialized community mental health program for people with AIDS in each of the Baltimore and Washington metropolitan areas. These should include services for significant others. (New)

c. Develop 250 additional slots for community mental health services. (Revised)

d. Provide 70 hours/week of clinical case consultation on HIV to mental health programs. (Revised)

e. Form mental health teams to provide direct service and consultation to other staff dealing with HIV related cases. (Moved back from 1989)

4. Addictions Services

a. Expand home health services for clients with AIDS to three more methadone programs in Baltimore City, and to one program each in

Prince George's, Anne Arundel and Baltimore Counties. (Unchanged)

b. Establish a 12 bed adult residential program in Baltimore City for IV drug users with AIDS. The program will provide 24 hour health care, supportive resources, medical care, drug treatment, social services, and strengthen client relationships with family members and significant others. (Unchanged)

c. Establish 200 new methadone maintenance slots in Baltimore City; 70 slots in Baltimore County; 35 new slots in Anne Arundel County; 50 new slots in Howard County; and 60 new slots in Prince George's County. (Revised)

d. Create four full-time counselling positions for pre- and post-test counselling of IV drug abusers at anonymous HIV test sites in Baltimore City and Prince George's County. (Unchanged)

e. Expand AIDS education and support group services by adding 7.5 full-time equivalent counsellors in Baltimore City. (New)

FY 1991 Actions

1. Counselling and Testing Services

   a. Increase service delivery capacity at CTS clinics based on seroprevalence and/or epidemiologic indicators. (New)

2. Patient Care

   a. Increase service delivery capacity at seropositive treatment clinics based on current seroprevalence and/or epidemiological indicators. (New)

   b. Establish regional DEU on the Eastern Shore and in Western Maryland. (Unchanged)

c. Increase number of health services coordinators in jurisdictions with increased HIV seroprevalence and in programs with increased caseload. (Revised)

d. Increase the number of slots in the Maryland AIDS Drug Assistance Program to 73. (Unchanged)

3. Mental Health Services

a. Add at least two specialized comprehensive community mental health programs. (New)

b. Provide at least 100 hours/week of case consultation. (New)

c. Enhance community mental health center staff to compensate for increased caseload related to HIV-related services. (New)

4. Addiction Services

a. Establish another 200 methadone maintenance slots in Baltimore City. (New)

FY 1992 Actions

1. Patient Care

a. Increase MADAP slots to 98. (Unchanged)

2. Mental Health Services

a. Evaluate need for purchase of care in acute care hospitals. (Revised)

b. Repeat patient services needs assessment survey. (New)

FY 1993 Actions (All New)

1. Patient Care

a. Perform a three-year evaluation of the effectiveness of the Diagnostic Evaluation Units.

b. Increase MADAP slots to 131.

2. Mental Health Services

   a. Modify services based on needs assessment.

3. Addictions Services

   a. Add 12 beds to the residential program in Baltimore City for IV drug abusers with AIDS.

## IV. Conclusion

The Department of Health and Mental Hygiene, the State agency charged with protecting and enhancing the health of Marylanders, has assumed the lead role in helping Maryland deal with the impact of the HIV epidemic. The response to the epidemic must be as far-reaching as the epidemic itself.

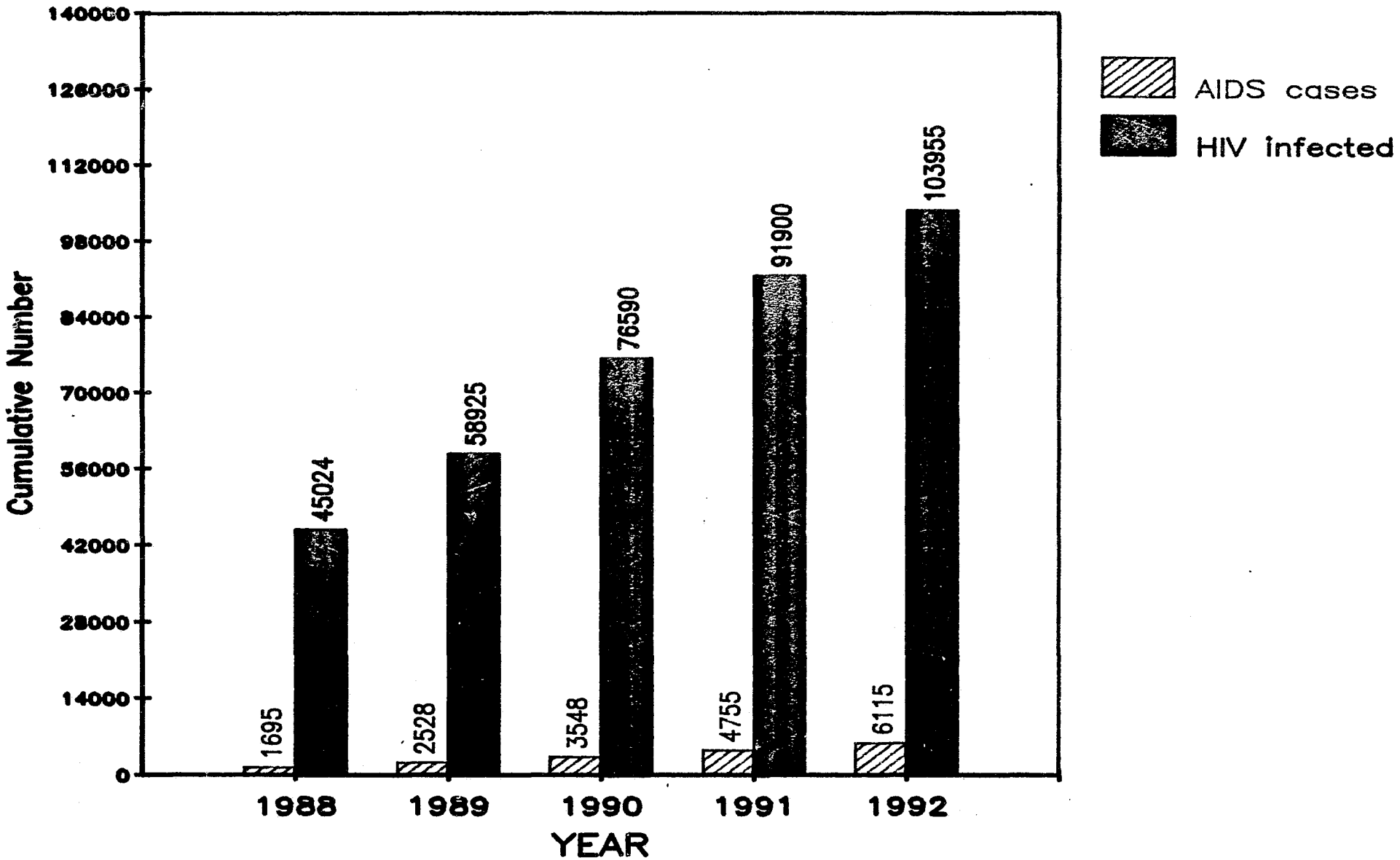
The AIDS Administration has developed a staff and budget (57 permanent positions and approximately 6 million dollars, including both federal and state funds, for FY 1989) to meet the challenge of the HIV epidemic. Epidemiologists are studying the course of the epidemic and evaluating the impact of programs; outreach and education staff are working with communities throughout Maryland to diminish risk-taking behaviors in our population; and health care professionals are addressing critical questions about infection control and treatment services.

The costs involved with this planned response to the epidemic may seem high. However, the choice must be to support prevention and care planning now, to reduce long-term costs of the epidemic; not to ignore the problem now, and pay later with disability and death of a much greater number of people and with the increasing burden of health care costs on society.

# A P P E N D I X

# ESTIMATED CUMULATIVE NUMBER OF CASES OF AIDS AND HIV INFECTED-SYMPTOMATIC/ASYMPTOMATIC PERSONS IN MARYLAND, 1988-1992

**Source: DHMH AIDS Administration**



# AIDS FIVE YEAR PLAN
## STATUS OF FY 1988 ACTION STEPS

| | FY 1988 ACTION STEPS | STATUS |
|---|---|---|
| Statewide Coordination: | Establish AIDS Action Council | Completed |
| | Develop plan committee/process for Council | Completed |
| | Develop comprehensive plan with public/private responsibilities | Deferred by Council |
| | Develop mechanism within Council to maximize grant funding | Not addressed by Council |
| Surveillance: | Enhance staffing | Completed |
| | Develop proposed legislation requiring anonymous, aggregate reporting of HIV seropositivity | Completed; law in effect |
| | Improve distribution of data | Completed |
| Prevention: | | |
| Gay and Bisexual Outreach | Establish community networks | Completed |
| | Use gay newspapers for outreach | Completed |
| | Plan regional outreach center for Baltimore City | Completed; to open Autumn 1988 |
| Minority Outreach | Establish community networks | Completed |
| | Use minority newspapers for outreach | Completed |
| | Plan outreach center in Baltimore City | Not completed; plan withdrawn |
| | Channel federal minority outreach funds to minority community | Completed |
| Intravenous Drug Users | Expand SOAP outreach/education program to Anne Arundel and Baltimore Counties | Services provided following different model |
| | Train addictions staff and require programs to provide each client with HIV counselling | Completed |
| Public Education | Develop multifaceted education program | Completed |

Appendix B

| | FY 1988 ACTION STEPS | STATUS |
|---|---|---|
| School Age Children | MSDE grant from CDC for pupil education program | Completed |
| | Require schools to implement HIV education program at three levels | Completed; (by-law in place) |
| | Peer outreach program through JSA Youth Service Bureau | Not completed |
| | Extend teen hotline beyond metropolitan Washington area | Not completed |
| Health Care Workers | Tailor professional education to meet needs of health care professionals | Completed |
| | Develop and disseminate infection control procedures | Completed |
| | Foster development of UMAB as a primary HIV training resource | Completed |
| Hotline | Award three-year hotline contract | Completed |
| Mental Hygiene | Hold four regional HIV workshops for community providers | Completed |
| | Consultants for HIV-related cases | Not completed |
| Treatment/Patient Services: | Reduce delays for CTS services | Completed |
| | Open CTS in Frederick County | Completed |
| | Subacute care beds - 9 to 18 needed | Completed |
| | Initiate Diagnostic Evaluation Units | Completed |
| | Expand network of HIV case managers | Completed |
| | Establish 75 new methadone slots | Completed |
| | Provide rapid medical intake for 50 additional addicts/month | Completed |
| | Establish home health care for 20 IVDU with AIDS | Completed |
| | Initiate AZT Program | Completed |

Appendix B

# AIDS FIVE YEAR PLAN
## ACTION STEPS
## OCTOBER, 1988

| | CY 1989 | CY 1990 | CY 1991 | CY 1992 | CY 1993 |
|---|---|---|---|---|---|
| Estimated Cumulative Number of AIDS Cases in Maryland | 2,582 | 3,548 | 4,755 | 6,115 | 7,611 |
| Estimated Number of HIV-Infected Persons in Maryland | 58,925 | 76,590 | 91,900 | 103 955 | 106,554 |

| | FY 1989 | FY 1990 | FY 1991 | FY 1992 | FY 1993 |
|---|---|---|---|---|---|
| Statewide Coordination | AIDS Partnership Council (APC) networking<br>Gov. AIDS Fact Sheet (bi-monthly)<br>Review of AIDS-related materials | APC reconsideration of community action planning process | | | |
| Epidemiology | | | | | |
| Surveillance | Add one case investigator. | New reporting regulations (symptomatic HIV+) require more staff<br>Biennial blind seroprevalence<br>Specific pediatric case monitoring | Analyze data from new reporting of symptomatic HIV+ individuals<br>Seroprevalence studies defined by CDC | Biennial blind seroprevalence studies | Increase staff as as needed |
| Special Studies | Contract with U. MD. for data management<br>KAB studies:<br>general population<br>family planning clients<br>ethnic minorities<br>college-aged youth<br>Pilot project on family communication and information transfer | KAB studies to accompany blind seroprevalence studies<br>Assess educational interventions<br>Second phase of family communication study | Repeat KAB studies done in FY 1989<br>Add computer programmer | KAB studies to accompany blind seroprevalence<br>Assess educational interventions | Repeat KAB studies done in FY 1991 |
| Prevention | | | | | |
| Gay & Bisexual Outreach | Outreach center in Baltimore gay/bisexual community<br>Target ethnic minority males, sexual minority youth, deaf population | Plan for STOP AIDS Project in Balto/Wash. Cooridor | Implement STOP AIDS Project in Balto/Wash. Cooridor<br>Plan expansion to other areas | Evaluate STOP AIDS Project<br>Open regional outreach center in the D.C. metro area | Establish outreach center in W. Md. & E. Shore<br>Develop a regional interstate outreach program<br>Evaluate program |
| Outreach to Minorities | Outreach center on Eastern Shore<br>Hispanic hotline in D.C. metro area<br>Training program for community health aides | Establish a consortium of black colleges as training/collaboration resource for community-based organizations (CBO's)<br>Expand funding for CBO's | Evaluate community health aide training<br>Regional workshops/conferences | Increase regional outreach staff from 4 to 6<br>Expand programs deemed most successful | Evaluate programs<br>Increase regional outreach staff from 6 to 8<br>Establish ongoing training programs for minority CBO's |

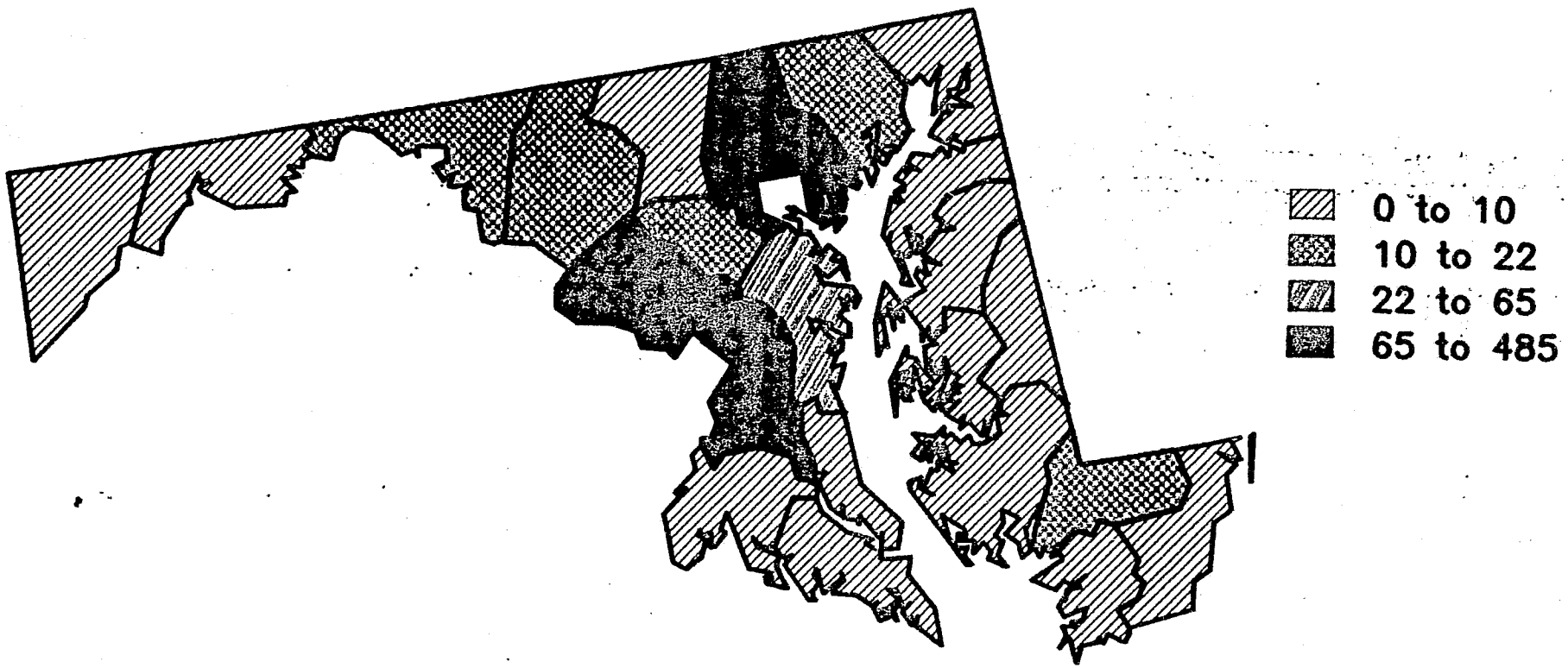
Appendix C

| | FY 1989 | FY 1990 | FY 1991 | FY 1992 | FY 1993 |
|---|---|---|---|---|---|
| Intravenous Drug Users (IVDU) | Training and updates for all addictions counselors in AIDS risk assessment/ counselling | AIDS outreach/prevention coordinators in 4 regions<br>Expand SOAP program in Baltimore City, P.G., and the outreach/ education program in A.A. County | | | |
| Public Education | Add 2 trainers and 1 librarian<br>Place regional AIDS educators in local health depts.<br>Billboard campaign for AIDS Awareness Month | Add new skill-building workshops<br>Consultation/training to private sector | Rebid hotline contract<br>Expand regional educators from 6 to 7 | Expand regional educators from 7 to 8 | Evaluate programs<br>Expand regional educator program from 8 to 10<br>Media campaign |
| Youth Outreach | Establish separate operating division<br>Beach outreach program in Ocean City | Develop mechanism for colleges/universities to share AIDS info materials<br>Focus on parents w.r.t. Education Bylaw<br>Fund demonstation project in pregnancy and HIV prevention | Add staff person to focus on incorporating AIDS education into "Individual Education Plan" for children with special needs | Establish campus site as center of campus network<br>Explore adding AIDS materials into GED and literacy programs | Establish youth outreach center in D.C. metro area<br>Establish inter-agency committee of State agencies to reach out-of-school youth |
| Mental Health | .5 FTE staff person for AIDS issues<br>6 regional educational programs for mental health providers | | | | |
| Professional Education | Expand staff<br>Nurse liaison at UMAB professional schools<br>KAB of dentists<br>Dental health professional at State<br>Publish Communicable Disease Bulletin<br>DEU's as education sites | Expand UMAB link-curriculum development<br>KAB study of physicians<br>Pilot health care worker consultation service: 4 LHD's<br>Expand infection control staff | Introduce HIV curriculum into 6 UMAB professional schools<br>KAB of nurses<br>Add 6 LHD's to health care worker consultation demonstration<br>Examine means to require HIV education for health care professionals | KAB of allied health professionals<br>Expand health care worker consultation statewide | Evaluate UMAB programs<br>Develop programs for allied health professionals<br>Evaluate data from health care worker consultation service |

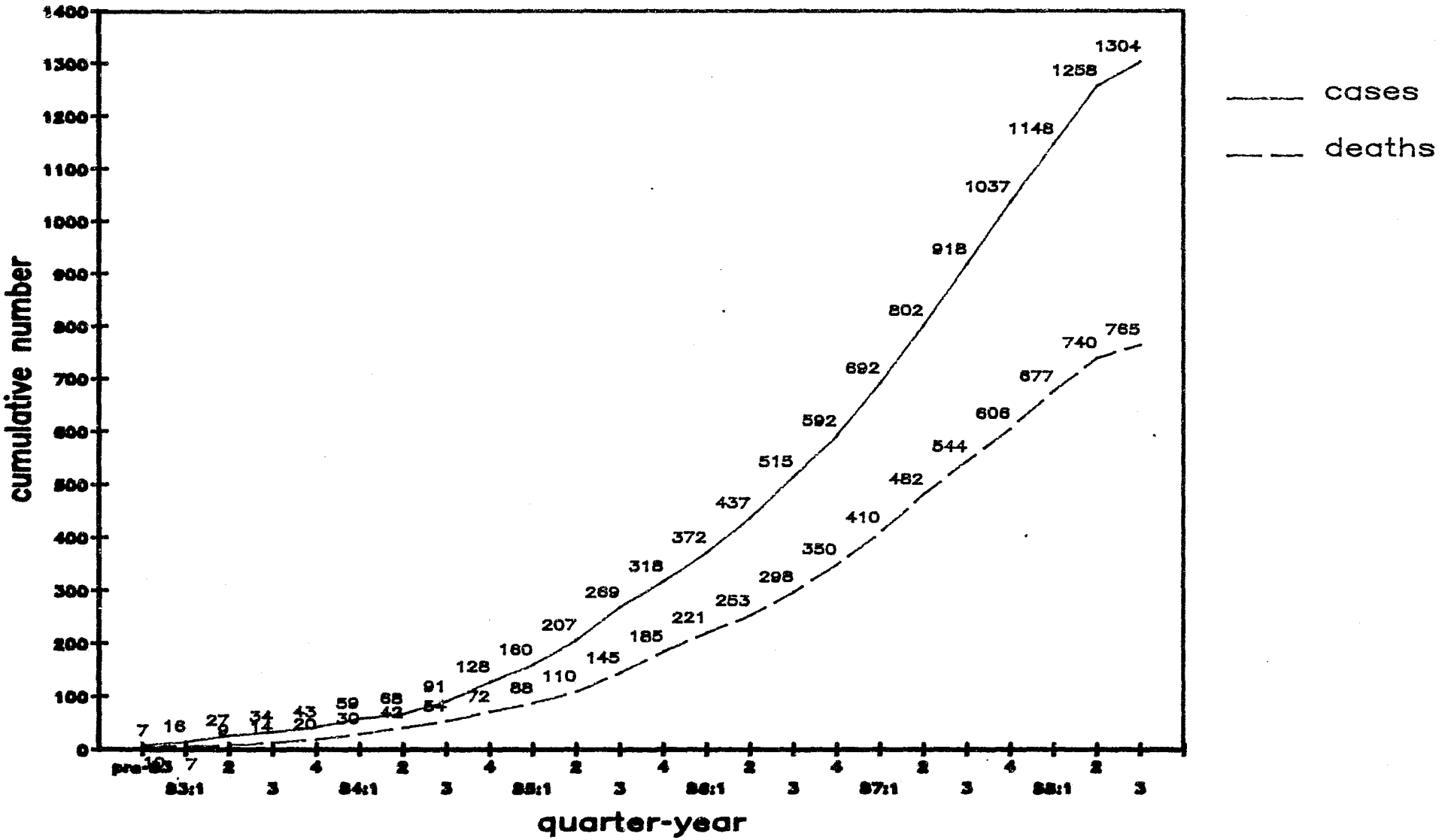
| | FY 1989 | FY 1990 | FY 1991 | FY 1992 | FY 1993 |
|---|---|---|---|---|---|
| **Health Services** | | | | | |
| Counselling & Testing Services (CTS) | Expand into LHD STD, FP, & maternity clinics<br>Increase services at LHD CTS clinics with new funding<br>Nurse to train CTS staff | Add 2 social workers for training CTS staff and assisting with job stress | Increase services as needed | | |
| Patient Care | Seropositive follow-up clinics: PG & Balto City<br>DEU for PG/Montgomery Counties<br>Sub-contract MADAP funds (Federal) | Expand services as needed<br>Obtain new funding for MADAP 54 slots | DEU for E. Shore & W. Md.<br>MADAP slots: 73 | MADAP slots: 98 | Evaluate effectiveness of DEU<br>MADAP slots: 131 |
| Mental Health Services | Needs assessment of HIV seropositive population | Specialized community mental health program for persons with AIDS & their families: 1 each for Balto. & Wash. area<br>Add 250 CMHC slots<br>HIV case consultation 70 hr/wk<br>Mental health teams for services/consultation for HIV related cases | Add 2 specialized community mental health programs<br>HIV case consultation 100 hr/wk<br>Enhance CMHC staff as needed for increased caseload | Evaluate need for purchase of care in acute-care hospitals<br>Repeat needs assessment from FY 1989 | Modify services based on needs assessment |
| Addictions Services | 60 slot methadone to abstinence program in Montgomery County<br>AIDS education/ support groups for seropositive in 7 Balto. City & 1 PG program | Expand home health services to home-bound methadone patients with HIV disease – 3 in Balto. City & 1 each in A.A., P.G. & Balto. Counties<br>Establish 12-bed residential program for IVDU with AIDS in Balto. City<br>Add 415 methadone slots<br>Create 4 counselling positions for anonymous CTS sites to serve IVDU | Add 200 methadone slots | | Expand residential program for IVDU with AIDS by 12 beds |

Appendix C

# CUMULATIVE MARYLAND AIDS CASES
## January 1,1981-August 31,1988
## N = 1304



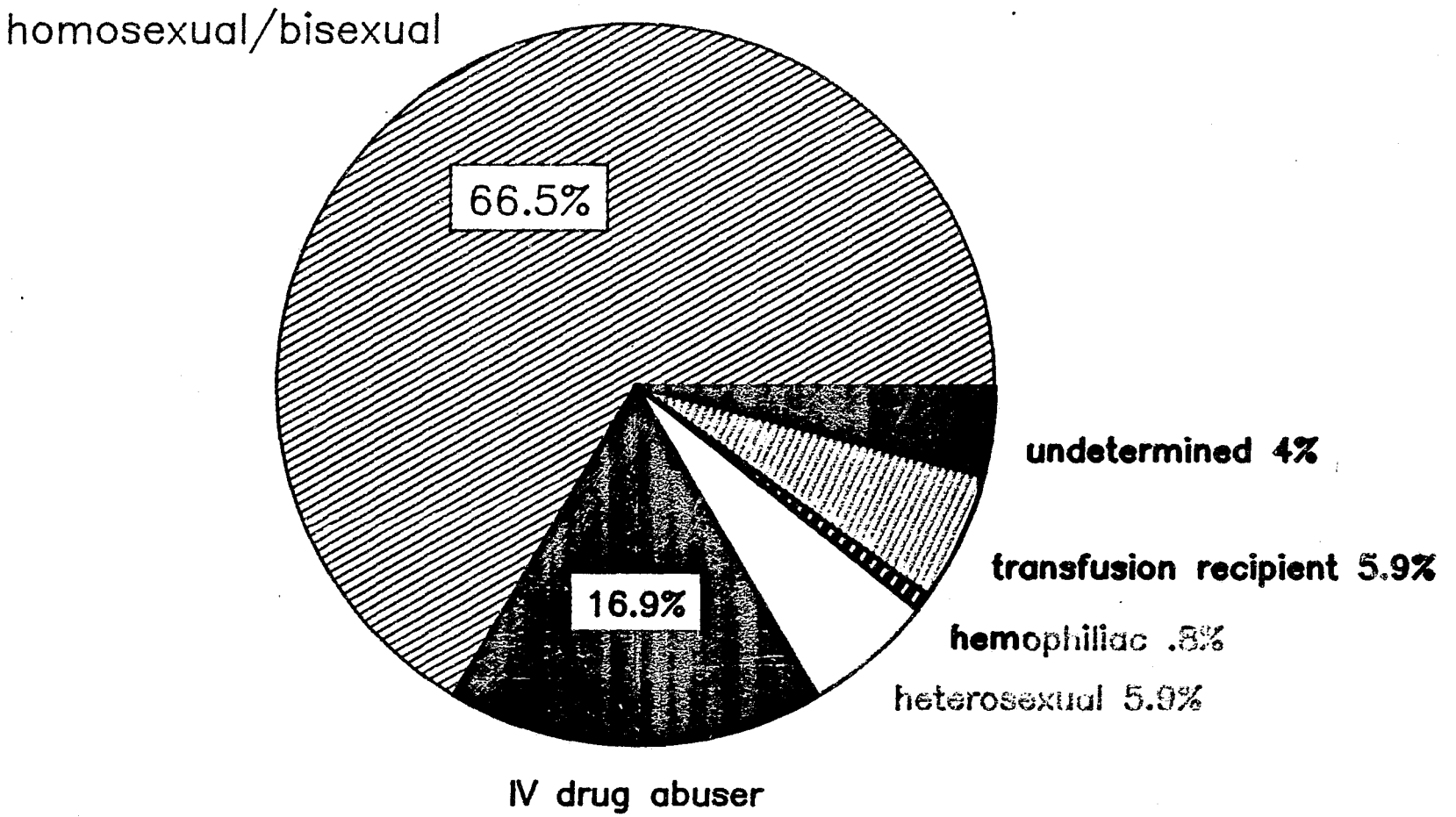
# MARYLAND AIDS CASES AND DEATHS
## CUMULATIVE NUMBER BY QUARTER-YEAR OF DIAGNOSIS AND DEATH 1983-AUGUST 31,1988




**Source: DHMH AIDS Administration**

Appendix E

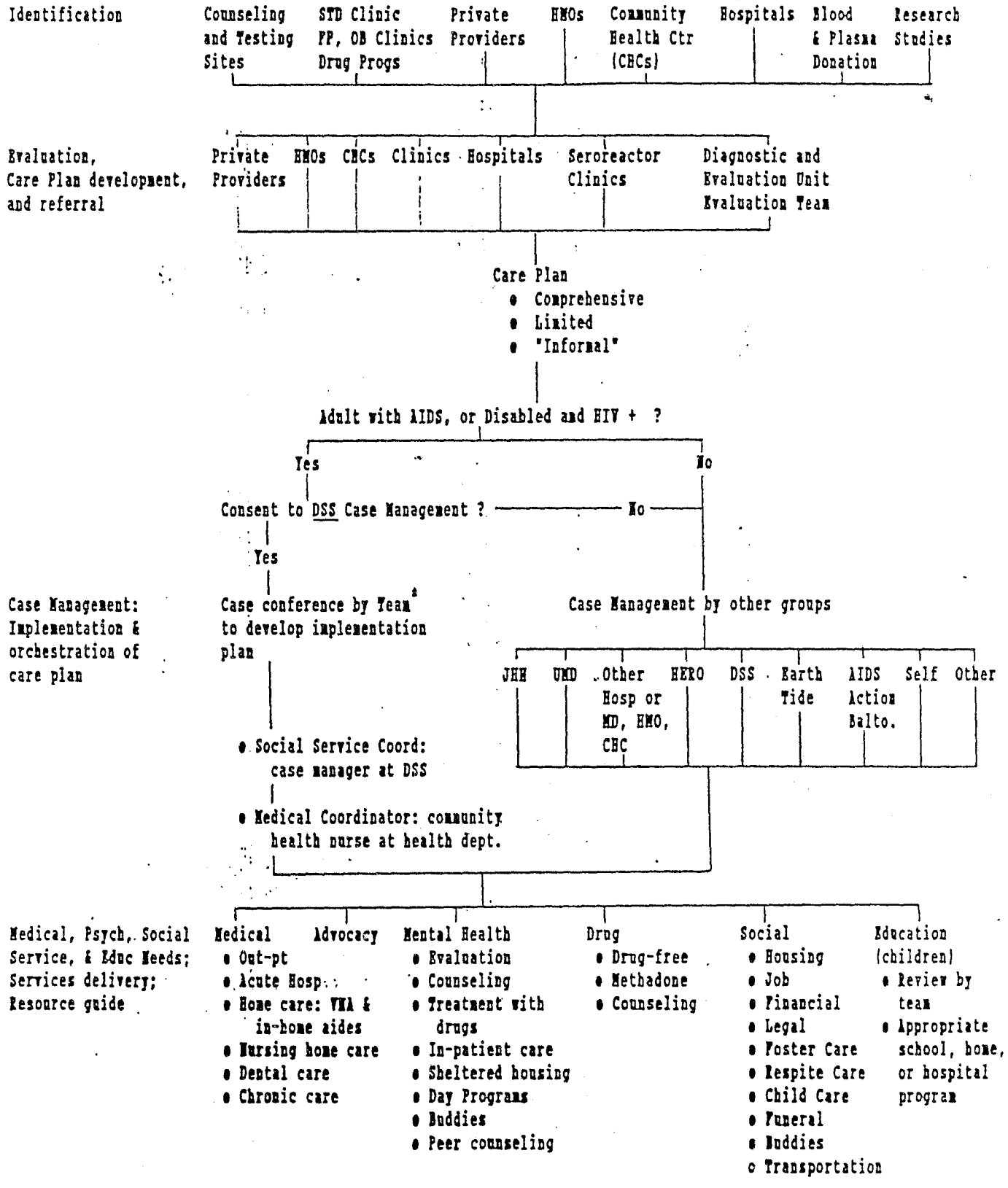
# MARYLAND ADULT AIDS CASES
## BY RISK
## 1981-August 31,1988




Source: DHMH AIDS Administration

OVERVIEW OF IDENTIFICATION, EVALUATION, AND CASE MANAGEMENT OF ADULTS AND CHILDREN WITH HIV OR AIDS IN MARYLAND

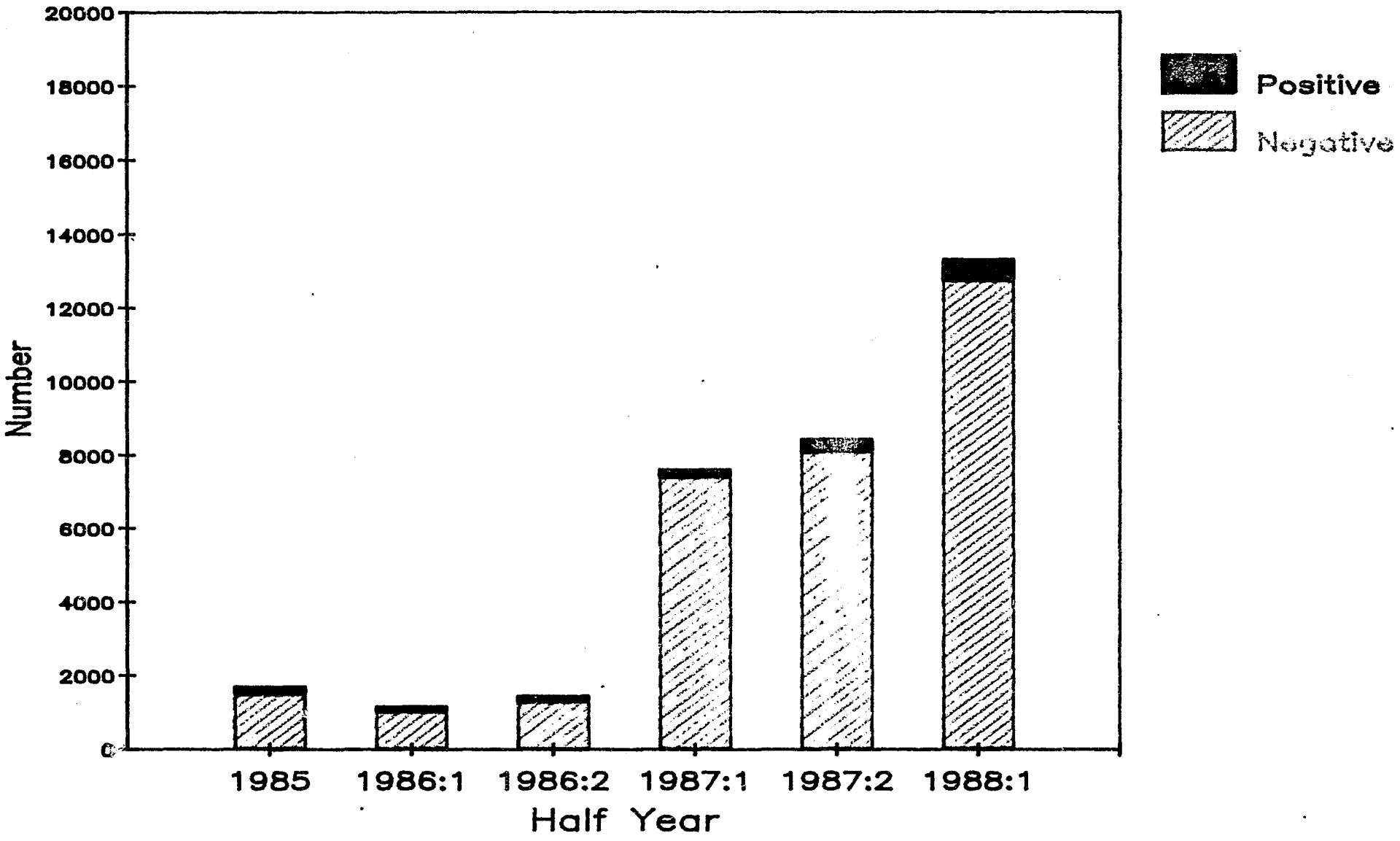
6/26/88




* Team: DSS Case Manager, Medical Coordinator (Community Health Nurse), CBO Rep., Mental Health Rep., Substance Abuse Treatment Rep.

DEVELOPED IN CONJUNCTION WITH THE MARYLAND DEPT OF HUMAN RESOURCES, DEPT OF HEALTH AND MENTAL HYGIENE, AND BALTIMORE CITY HEALTH DEPARTMENT

# POSITIVE AND NEGATIVE RESULTS FROM MARYLAND COUNSELING AND TESTING SITES BY HALF YEAR 1985-1988




Source: Maryland AIDS Administration